# Brooke Army Medical Center
# JCAHO Survey 15-19 December 2003: After Action Report

**Surveyors:**
Nelson Sirlin – Physician and Team Leader
Jacqueline Duplantis – Nurse
Thomas Treat – Administrator and Ambulatory
Lloyd Sidwell – Behavioral Health

**BAMC had a great survey**. We had a large room set up for JCAHO Surveyor headquarters, with a window which they truly appreciated. The primary document review session was conducted in that room. The EC documents were maintained in Logistics Division.

**Document review session**:
1. Asked for list of unapproved abbreviations.
2. Medical Staff Bylaws
3. Plan for Provision of Patient Care
4. Medical Record Delinquency Data
5. Statement of Conditions Part IV (signed).
6. Autopsy criteria
7. Medical Staff peer review policy
8. Example of PI that had sustained performance improvement

**PI Overview**
1. Recommend an interdisciplinary approach, presenters included two physicians, the Chair of the PI FMT, the Chief of Patient Safety, the Chair of the HR FMT.
2. Topics included: Hospital PI Committee and communication structure, PI Model, PI prioritization, Patient Safety (NPSG, RCAs, HFMEAs), ORYX: which included the team presentation, and staffing effectiveness.
3. Questions included:
   - Questions regarding the FMEA
   - Was the staffing effectiveness review beneficial?

**Leadership Interview**
1. How was Performance Improvement Prioritization done? Through the Quality Management Advisory Council and Performance Improvement Committee endorsed by the Executive Committee.
2. Coordination with the community re: disaster planning.
3. Interested in use of CHCS and MEDBASE
4. How/when do you notify patients of adverse outcomes? Disclosing medical errors that resulted in adverse outcome/injury to patients. BAMC Medical Staff Bylaws state that the attending will disclose this to the patient/patient's family.
5. Interested in Pain Management. Outcome measures, documentation measures and patient satisfaction measures.
6. Interested in Clinical Practice Guidelines. Plan to demonstrate this in the clinics.
7. Patient Satisfaction: Dissatisfaction: Parking.
8. What projects is BAMC working on that are resource constrained?
9. Do you have any examples of not being in compliance with other regulatory agencies, i.e. OSHA? What did you do about it? Did you get any "bad press" from it?
10. Describe the relationships between your hospital and other DOD hospitals.
11. Who runs your disaster drills?
12. How are resources stretched to meet priorities and "nice to haves?"
13. Is your pain management program better now than in the past?
14. How do you determine which CPGs to use?
15. What issues have been raised in patient satisfaction surveys that have resulted in improvements?

**Patient Safety and Medication Administration Interview**

1. Recommend having the Chairperson of the P&T Committee participate.
2. Who is on the P&T Committee? It is a joint committee with Wilford Hall. Multidisciplinary with nurses and doctors, department chiefs, pharmacists and patient safety. COL Ellis chairs the committee (or COL Longfield in COL Ellis' absence).
3. What medications are in the formulary? DOD core formulary and any other drugs needed for the type of services provided (such as chemotherapy drugs). P&T Committee oversees the hospital formulary list of medications, what is added to it and what is removed.
4. How is it determined what medications will be available in clinical areas? Joint effort between Pharmacy and nursing and the type of patients on the ward.
5. How are staff names added and deleted from Pyxis, especially contract and short term employees? Scrubbed by Pyxis coordinator about every 45 days (recommended more often). Nurses scrub list weekly and send changes to Pyxis coordinator.
6. Do you have a 'sample drug policy'? Yes, we have a No Drug Sample Policy. All drug reps must go through the pharmacy.
7. Who can give medication? Page 12 of BAMC Memo 40-22 says that people other than nurses and doctors can be approved to give meds. Who might that be? Example: staff such as the nuclear pharmacist.
8. How do patients access medications from the clinics? On site Pharmacy, Urgent Care Clinic, Tri-care mail order and retail programs.
9. Do you have a 24-hour pharmacy? Yes, therefore we do not have non-pharmacy staff going into the pharmacy after regular duty hours.
10. What is your process for investigational drugs? All patients must carry a card that they are instructed to show providers that describes the process for the provider to find out more about the investigational program the patient is in. CHCS also lists all investigational drugs the patient is on (with IRx) in front of the drug name.
11. What is your process for medication errors reporting and how do you encourage reporting? Patient Safety is the central repository for all med errors. Pharmacy also reviews all med errors. Errors are reported to the P&T Committee quarterly. Near misses are encouraged and rewarded. Anonymous reporting is accepted. 80% of pharmacy reported incidents are near misses. Use of bar-coding for patient identification and for drug identification was discussed theoretically.
12. National Patient Safety Goals: *Whether we had been in compliance since January 2003*
13. How well does your patient identification program work? The surveyors will observe staff members administering medication. And may ask patients.
14. Surgical Site identification/ Final Time Out, what is your policy and do physicians participate in the process? We have an interdisciplinary process that includes the patient whenever possible. The physician is included in the process. Is there a Final Time Out process used in other areas besides the OR, such as the clinics, wards, Special Procedures? Yes, a final time out note is available for these areas.
15. What is your process for verbal order read back?
    - On the wards and clinics the order is given by the physician and written down and read back to the physician. In CIS the check box is checked that the order was read back.
    - What is done in the OR? OR staff repeat back the order, show the doctor the container and repeat back again the order, and document medication in CIS. Surveyors recommended also writing it on the grease boards.

    What about doctors and verbal order read backs of orders given by a doctor to an Intern or Resident? Our response was that physicians work in a collegial climate without giving orders to each other, rather they discuss the cases and discuss in broad terms the treatment process. The surveyors felt that they should also be required to meet the same standards. After the meeting, the nurse surveyor was shown an e-mail from Rick Croteau at JCAHO that states: "In the scenario of an attending giving an order to a resident, we make distinctions between an attending telling a resident to 'put the patient on digoxin' versus 'put the patient on digoxin 0.25 mg IM q 12 hours.' In the former example, read-back is not required. In the latter example, read-back is required since this is a formal order.

16. What have you done to improve the safety of infusion Pump and do you have free flow devices here? Medical Maintenance addressed that the JCAHO recommendations and ECRI input was used to ensure that no free flow devices are at BAMC.
17. What have you done to ensure that clinical alarms are audible? Medical Maintenance, along with Occupational Health, surveyed each clinical area separately, checking noise levels at the highest level of the day and defaulted all clinical alarms so that the lowest volume that could be set by clinical personnel was loud enough to be heard at any time. It was done with input from nursing.

**Human Resource Interview**

1. One of the standards that plagues hospitals has to do with the competency assessment and training of non-privileged providers - this was problematic for BAMC during 2000 JCAHO survey. The surveyors spent 2 hours in the Human Resource Interview. COL Mundy gave them a powerpoint presentation then the surveyors scrutinized 20 CDFs. LTC Kim Armstrong and her team were given very positive feedback from the surveyors, who found that all of the CDFs were in complete compliance with the JCAHO standards.
2. Asked why we privileged allied health providers. One surveyor felt that it was to circumvent the HR standards, this was discussed briefly.

**Medical Staff Credentials Interview**

1. Must have performance expectations
2. If you use a privileging list rather than core privileging, you must have performance data on each element
3. The surveyor differentiated between case review and peer review. Case review is an educational process. Peer review is reviewing a specific provider with the consideration of privileging action.
4. Peer review:
   - Is undertaken because case review indicates an unacceptable trend
   - Must provide time frame (Begin and end dates)
   - Should have criteria that would generate an external review
   - Must have definition of “peer” (same specialty, same discipline)
   - Define how LIP will be involved
   - How will minority opinion be received?

**CMS, OR, PACU and general clinical review**

1. Want to look at OR schedule today, pick three charts, & review privileges of those providers doing procedure.
2. Number of OR rooms
3. Number of cases per month
4. Percent of cases that are ambulatory
5. Do you operate on children? (discussed we do only same day surg w/peds)
6. Number of heart cases per month
7. Number of providers (MD, CRNA, Residents....)
8. CRNA can practice by self? Who privileges? (medical staff)
9. Talk me through the process if I presented for a Left inguinal hernia
   - -who does the history, physical, consent?
   - -how is schedule for procedures done?
   - -what would happen if pt presents, without history or physical?
   - -when does marking of surgical site occur?
   - -when does final time out occur... in OR suite...is pt awake?
10. Impressed with triple check system but encouraged to monitor system (failure mode analysis) as every system can have flaws/not perfect. Be careful with pt having multiple procedures, pts in prone positions, and "captain of the ship" situations.
11. If sponge count was off what happens, are there policies & procedures?
12. Do you do any fire drills in OR, procedures, everyone knows how to turn off gas?
13. Big discussion on beards & fires in OR (beard traps oxygen thus increasing fire risk...put K-Y as non-conductive agent to avoid issue)

14. Do you allow product representatives to come to OR? Do you provide orientation/review HIPAA?
15. Do you get pt permission for vendors to observe/consult case?
16. Do you call pt with closed or open response? (Is my procto here?)
17. Tell me about PI in your area (discussed PI about case cancellations)
18. Any problems with sterilizer/wet packs?
19. Suppose you have an unexpected death in the OR of uncertain etiology, how do you handle (policies, procedures).
20. Where do providers get narcotics? How is administration & waste documented?
21. If surgeon request medication from field how is this handled? (this lead to great discussion, was this a verbal order or just restocking item...courier service)
22. Discussed ISMP 3 high risk reasons for errors with verbal orders in OR setting
    a. music and lighting
    b. mask
    c. language/comprehension
    d. -talked about facility that use grease boards to write orders down - idea he was trying to see: verbal orders written down and read back
23. Are there any medication errors?
24. Where are your MH drugs kept/stored, how secure?
25. Where do you keep your sterile water? (looking for sterile water for irrigation not kept with medications to avoid mixing/IV error)
26. Do you have a malignant hypothermia protocol?
27. Who stocks/prepares anesthesia cart? (Anesthesia techs) ***found unlabeled syringe with medication inside locked cart
28. Do you have ephedrine in your anesthesia cart? (controlled substance in our facility ans=no)
29. Do you have any concentrated electrolytes in your anesthesia cart?
30. Again if keep emergency medications outside of crash cart this is ok but must have system for immediate restock/break away lock/shrink wrapped!!!!
31. Look alike and sound alike drugs need to be separated. Again saw medications together look/sound alike, multiple strengths (need to down size)
32. Stepped back for others during chart review. Able to hear a few questions
33. -What was pt here for?
34. -Show history & physical
35. -Show me the advance directive, when is this initiated?
36. -Starting 1 Jan 04 need to have nursing protocols to remove idea that NSG prescribing (found multiple orders for pain/nausea/vomiting but left Nursing to decide when & how to apply... more direction: give percocet if pt post procedure pain score increased by___)
37. JCAHO standard Nursing Care Plans TX1
38. Reviewed pt identified by two pt identifiers when presents to same day surgery for check in.
39. Reviewed that screening room had safety plugs as they triaged pediatric pts
40. DELETE
41. Address that three non-spiked IV bags hanging on pole waiting for use. (concerned for possible malicious tampering)
42. Looked at syringes in staging area for IV starts.
43. Asked about the 30 day vial policy.
44. Looked at blood refrigerator. Is it being used to store blood/blood products? (many places in US removing and rely on direct service of blood bank to reduce errors. Discussed pharmacy oversight coming 1 Jan 2004, not issue if direct from blood bank and used on pt. If stored outside blood bank may become pharmacy issue for refrigerator inspection...deferred to Darryl Rich at JCAHO)
45. Looked at decontamination room
46. As walked by oxygen shut off valve asked if NSG knew how to turn off.
47. Noticed only adult crash cart in OR (told peds out in PACU). My personal concern if adult there why not peds there?
48. Looked at medication stock carts in OR cores.
49. -What is par level? Noticed large amount of stock
50. What is preferred method of sterilization?

51. Show me where MH drugs kept. (kept in locked room & break away lock on cart)
52. Had Nursing show him how to see if provider was privileged to perform specific surgeries listed on case for today.
53. CMS: who makes up crash carts? Enjoyed presentation by NCOIC on CMS. (small amount of time here).

**Sedating and Procedure Areas**

1. If you provide sedation or anesthesia:
   a. Complete an H&P
   b. Document that the patient is an acceptable candidate for sedation.
   c. Document an airway assessment
   d. ASA score
   e. Document the re-evaluation immediately before sedation/anesthesia.
2. If you do procedures, document the final time out.

**All Clinical Areas**

1. Pre-select charts for the surveyors to review! Therefore you can take advantage if they give you a choice.
2. Have the interdisciplinary team present and interacting.
3. Pain. Pain must be re-assessed after an intervention and after a procedure using a quantitative scale i.e. 1-10. Be ready to discuss pain assessment for neonates, children and non-communicative patients.
4. All syringes of medications must be labeled.
5. Know what your PAR levels are and how you maintain them.
6. Staff should be ready to answer questions about current PI projects and what they think should be the next PI project.
7. Clean out your supply rooms - keep 18 inches from ceiling.
8. Implementation of National Patient Safety Goals (Checked audible alarms, Verbal order must be read back - inpatient and outpatient. etc.)
9. Infection control
10. POCT
11. Medical Staff peer review. Recommended that we conduct case review, then if we see what appears to be an adverse trend conduct peer review. This concept will be discussed further in the MSEC.
12. Performance Improvement - if you have a power point presentation, ask the surveyor if he/she would like to see it, tell them how long it will take.
13. They keep looking for outdated items
14. Cleanliness
15. Infection Control -handwashing!
16. Pertinent Sentinel Event alerts
17. Crash carts, refrigerators
18. Patient education
19. Consents must be filled out in layman's terminology and as thoroughly as possible.
20. Know your patients very well. All surveyors expect to have an in-depth discussion regarding their assessment and plan of care.
21. Interdisciplinary communication and know what all team members are planning.
22. Know how the medications that are not in Pyxis are kept at an acceptable stock level, know the stock level.
23. When would you ask for an ethics consultation? Have you ever consulted the ethics committee - remember think interdisciplinary involvement.
24. Know how to shut off piped in gas, and under what conditions
25. Refrigerator temps, noting corrective actions and re-assessment.
26. Know your PI initiatives and the results (outcome measures).
27. Know the Patient Safety Goals that are pertinent to you and your area.
28. The surveyors ask staff members about their competency. How they were oriented and trained.
29. Crash carts - checked, know how to use the defibrillator.

30. Blood transfusions - checking to see if we follow our policy re: Patient ID, vital signs etc.
31. If you provide care to children be prepared to discuss child safety and staff competency.
32. Asked if clinical staff could have acrylic or other type of artificial nails.

**Ward visits**:

1. Typically chose 2 patients to review in depth with the interdisciplinary team. Know your patients well! Daily goals.
2. Watch the use of unapproved abbreviations. Check BAMC Memo 40-400.
3. How do you identify errors? How do you report errors?
4. Resident supervisory
5. Nursing assessments
6. H&Ps
7. How do you receive patient from the ED, from another ward (continuity of care issues)
8. How do you involve the family in discharge planning
9. Skin assessment
10. **Critical Care**: Focused on methods to decrease ventilator acquired pneumonia.
    a. Handwashing
    b. Elevate HOB
    c. Prevent condensation
    d. Oral care q4 hours, brushing q12hours
    11. Daily Goals
12. Dietary assessments
13. When you document allergies, do you document the type of reaction?
14. Restraints - Reviewed all of the standards.
15. Admission Data. She felt comfortable that we could quickly show where data could be located if it was not annotated in either the H&P or Nursing Admission Assessment or that we could verbalize that data that could not be gathered secondary to patient condition was gathered when feasible and was known by the healthcare team.
16. Emphasis was placed on the initial assessment of pain and that it was annotated.
17. She verified that the operative physician's "Operation Report" was entered within a timely fashion upon completion of the surgical procedure.
18. She asked us to describe any of our PI initiatives that we have worked on and we were able to highlight several.
19. The surveyor pointed out that on the DA Form 7389, Medical Record - Anesthesia, there was inconsistency throughout the facility regarding the block on the left-hand sided entitled "Patient Recheck" that contains the question "OK for PROCEDURE?" In most she found that anesthesia answered the question with a "Yes" or "Y" but on this form only the time was annotated indicating when the anesthesia provided rechecked the patient prior to induction.

**Ambulatory Care**

1. Be prepared to present your patient demographics.
2. Interested in physicians' involvement with peer outside our MTF. Master Problem Lists - be prepared to demonstrate MEDBASE.
3. Interdisciplinary care and interdisciplinary communication
4. Chart reviews
5. Focus on Interdisciplinary communication and care planning. If a patient is being seen by more than one provider, more than one clinic, how is the healthcare planned?

**Infectious Disease Clinic**

1. Small pox vaccination, do you have a program? Any problems with it?
2. Do you ever have cases that lead to an ethical dilemma? Do you have an ethics committee/path to pursue if needed?
3. Do you have issues with VRE, MRSA that the community has?
4. What are the 3-4 most common diagnosis seen in clinic?

5. Asked head nurse besides being a nurse what qualifications does he have to have to work in this clinic (Masters in Education, explained the need for pt understanding of disease process & treatment plan to increase adherence/outcome)
6. If acquire HIV in military what is your status?
7. Do you review clinic records for timeliness, accuracy, legibility, completeness?
8. Do you have any PI?
9. What is hardest part of job (asked to head nurse)?
10. What is incidence of HIV in military vs community?
11. When you have a pt. newly dx. with HIV how do you work with family?
12. How do you know spouse/partner has been told of pt's HIV status?
13. Do you have a system in place to assure that a false results would not be given to pt (discussed hemolytic blood transfusion mix-ups, inferring HIV status mix-ups)
14. If you order labs how do you know they have been done? How do you get results back?
15. If you had all the resources you could get for the clinic what would you wish for/change?

**Peds/Adol Clinic**

1. Questions about EFMP
2. Resident rotation numbers
3. Are there significant numbers of ped/adol pts seen in the community that would not be picked up by the system/EFMP?
4. Wanted to hear about the interdisciplinary team involvement.

**Emergency Department Visit**:

1. Dr. Sirlin started with interdisciplinary group in small conference room; we discussed:
   a. Staffing (how many docs, nurses, residents), how do we know we are adequately staffed.
   b. He was interested in how we credential providers who are deploying and how we credential their replacements, and how we re-privilege them after their return. He also wanted to know if all of the physicians were board certified.
   c. If he was a faculty physician what would we do to re-privilege him (peer review, transfusion practice, medication profiling).
   d. If he was a patient with chest pain in an ambulance how would we get him into the ED, who would he see first, who would ask him if he had an advance directive, who would get him to the cath lab or get him thrombolytics. Then what would we do if he spoke Spanish only, and/or became combative. We discussed translators and two types of restraint after trying other methods.
   e. He asked about how we know residents can do specific procedures,
   f. How do we identify patients and do we REALLY do it, and do we have a procedure for readbacks, and do we do them. We discussed MedTeams and patient armbands.
2. We then walked around the unit, starting in the decon area and how we identify possible decon issues, to include radiation.
3. We demonstrated signing in, triage to ED or UCC, and flow to both places.
4. We walked into rooms in the UCC and checked for medications/samples (none), then to the ED proper.
5. Trauma room:looked at the refrigerator and level of stockage of various drugs, where are the concentrated electrolytes, and how do we restock drugs in the trauma and medication room. He liked the layout of the medication room, neat, orderly, and recommended we look at look-alike sound-alike drugs near each other for next year.
6. We finished with looking at consent form for blood, etc., and form for procedural sedation. He liked them both.
7. He looked at three charts, and was impressed that they were legible, and a medical student chart had a student note, a resident note, and a staff note.
8. Trauma room had IV solutions already prepared, physician concerned about sabotage.

**OB-GYN Clinic**

1. Ms DuPlantis toured the clinic with Dr Williams, SGT Castro and myself.
2. She wanted to see an exam room. She asked if we used disposable or metal speculums. I showed her the warmer we used and she was impressed we warmed the KY jelly. She asked how we cleaned the speculums. I described the process with soaking with Sterizyme and sending to CMS.
3. We stopped at the PI board and PV2 Lucas, 91W, explained the board to her. She asked about what would be done if the documentation was not maintained and PV2 Lucas was able to answer this to Ms DuPlantis' satisfaction.
4. She wanted to see the Dirty Utility Room. She asked if our KOH/Wet Preps were done in that room. (Not anymore!).
5. We took her to the "Lab Room". She questioned if the providers had to carry slides from exam rooms to the lab room. It was explained they carried test tubes and the slides were prepared in the lab room. She did note that there was no sink in the lab room. It is directly outside the room.
6. She asked about the procedures done in the clinic
7. She was taken to the Conference Room and Dr Morton presented the Power Point Briefing.
   - She asked about our GYN Onc Division. Dr Kost talked to that. (Impressed)
   - She asked questions about the OB CPG and was given a booklet all pregnant women get (She was impressed)
   - She asked about our Midwife's duties and if she does deliveres
   - She asked and discussed the "morning after" pill in the news
   - She asked about the surgical procedures done and if the Residents got enough procedures (Dr Morton and Kambiss were able to give some numbers)
   - Our second PI (the after-hours clinic project) was discussed. She had some questions and suggestions for when we try again.
   - Discussed Patient Safety Goals in the Dept.
   - She wanted to review 2 records of procedures done that day or the day before. (We had scrubbed 3 OB and 3 P&D records - no procedures) She spent a very short time reviewing those records and had no comments or questions.
   - She did ask how we identified patients when they checked into the clinic. We explained the requirement to wear a photo ID in the hospital and that was used. She seemed enlightened that all patients and visitors had to wear photo ID's.

**Radiology**

1. Telemedicine: conversation about privileges by proxy
2. Number of residents
3. Resident supervision
4. Performance evaluations/profiling/peer review (process/reported ... be able to identify variation)
5. Do you take care of children? (age specific comp..if NSG walks in and turns up temp for infant would you know why, do you sedate children (anesthesia called)
6. Number of invasive procedures? How many use sedation?
7. Pt satisfaction
8. Availability of procedures (turn around time of request)?
9. How have you implemented the national pt safety goals?
10. Any one in this room involved in a root cause analysis?
11. Documentation of age specific competency
12. Any open positions (MD/tech)?
13. When was your last fire drill & did you get feed back from safety.
14. How would your department handle a mass casualty (EEP situation)
15. What do you do with request for procedures without enough info on them?
16. Special procedures, looked at pt chart for anesthesia donebefore time out and post time out by two different persons (NSG initial & provider after time out)
17. Looked at medication storage (what are par levels, how do you know that med will always be there, ok to have medications outside crash cart but need accountability)

**Pharmacy**

1. How are diversions of controlled substances handled? Per the surveyor, diversions are not medication errors. What happens to personnel involved in diversions? The surveyor stated that we need to be direct in resolution and not pass the problem to others in our profession.
2. How are refrigerator temperatures monitored? We keep temperature logs that are documented daily. Are all refrigerators on emergency power? Yes, in the pharmacy. Who is responsible for record keeping? How do you handle refrigerated drugs when there is a deviation in temperature? Call the manufacturer for guidance. What is the acceptable refrigerator temperature range? 35 to 45 degrees F (2 to 8 degrees C).
3. How do personnel receive training on medication errors? Through annual Synquest training (Patient Safety Program).
4. What are your Performance Improvement initiatives?
5. When drugs are ordered, do they go through Logistics first or do they come from the Prime Vendor directly?
6. How do you order influenza vaccine? How much do you order? Are problems with narcotic supplies handled immediately? Is ether stocked in the pharmacy?
7. In addition, the surveyor checked the following:
    - Narcotic count of Percocet
    - Narcotic count of morphine injection
    - CIS patient record for diagnosis, age, weight, allergies
    - Baker cassette procedures
    - Baker cassette logs
    - Support Pharmacy narcotic records for accountability and legibility
    - IV hoods for last inspection date
    - Ventilation of storage closet with flammable materials

**PT/OT/Cardiac Rehab**

1. He offered to listen to our briefing if we had one and then tour, or tour first and then brief.
2. We took the option of briefing first followed by a tour.
3. We each had a briefing prepared which covered our mission statement, team introductions, Scope of Care and Services, Workload Population, Top 5 ICD-9 Codes for the past year, Top 5 CPT-4 Codes for the past year, Staffing, Workload, Performance Improvement projects that we did, Ongoing/future PI Initiatives.
4. All three sections did their briefing and he asked questions as we went. OT did a desktop briefing on their PI project. He seemed to like that.
5. Then he looked at records from all three areas. Did not have any negative comments. Was interested in pain documentation and education. We had both documented adequately in the records he looked at.
6. Asked about staffing and whether or not it was adequate
7. Asked about the OIF reservists and their access to care
8. Asked about amputee care
9. Asked about attrition from the active component.
10. Seemed interested in BAMC's pursuit of GWOT dollars to help with staffing shortfalls as a result of increased demand on services from OIF patients.
11. Asked one of the staff about a future PI initiative
12. We then took him on a tour of the three areas but he was pressed for time and didn't linger in any of the areas.

**ASAP and Developmental Clinic Survey:**

1. Introduction to the ASAP staff, brief description of the background of each staff
2. Overview of the program, review of types of patients served, percentage of different diagnoses, process of the program, etc.
3. PI Initiative: number of patients successfully completing program.
4. Open records review. Mr. Sidwell especially liked the Therascribe notes. The format made it very easy to find everything and the notes were much easier to read than hand-written notes. Went over two cases with the counselors and seemed pleased by their presentations of the cases.
5. Closed records review. One chart had a discharge summary that was signed but not dated (not done on the Therascribe system).
6. Tour of area-no problems.
7. Surveyor reviewed the secretary's competency file and the two newest counselors' credentials files. Thought the competency file was very thorough. No problems here.
8. After the ASAP review Mr. Sidwell met with members of the Developmental Clinic, Dr. Greefkens (developmental pediatrician) and Dr. Greathouse (Assistant Chief of Child Psychology). Dr. Greathouse presented an overview of the Child and Adolescent Psychology Service, then the remainder of the time was spent with more focus on the Developmental Clinic. Dr. Greathouse and Dr. Greefkens did an overview of the clinic's processes, and the surveyor reviewed an integrated assessment summary. He seemed very impressed with the Developmental Clinic and recommended that we invite others to visit us as an "exemplary" program.

**POC :**
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